Record/Invoice Number: _____

STATE OF CONNECTICUT
Office of Health Care Access
Freedom of Information
Hospital Inpatient Discharge Data Request Form

Date: _____

The Office of Health Care Access (OHCA) maintains an acute care hospital inpatient discharge database and fills requests for aggregate health data from all interested individuals, institutions and other government agencies. Data released to interested parties however are subject to the provisions of section 19a-167g-94 of OHCA's Budget Review Regulations and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and other local, state and federal regulations relating to the maintenance of patient privacy.

Fees may be associated with responding to these requests. Only request forms that are fully completed will be considered. Discharge categories with fewer that six patients will be noted as less than six (<6).

For more information, contact Gloria Sancho at (860) 418-7027 or Gloria.Sancho@po.state.ct.us.

After submitting your request, you will be notified within four (4) business days whether: 1) the request has been approved for preparation, 2) the request has been denied because it involves confidential information or does not meet required thresholds, or 3) it cannot be readily determined until the report is prepared whether or not it meets required thresholds.

Please review Section 19a-167g-94 of OHCA's regulations (especially section (g) on pages 87-92) for an overview of the data request process, data elements collected, confidential data elements, and required thresholds **before** completing this request form.

INFORMATION REQUESTED – (PLEASE FILL OUT ALL INFORMATION AND ATTACH ADDITIONAL PAGES IF MORE SPACE IS REQUIRED)

1. **LIST OF DATA ELEMENTS TO BE INCLUDED:**

2. **DATA SELECTION CRITERIA (e.g., specific ICD-9-CM codes, DRG codes, demographic variables, or at least two contiguous zip codes, if zip code information is being requested):**

3. **TIME PERIOD FOR REQUESTED DATA** (Fiscal years available: 1991– Q1+Q2 of 2005):

4. **SAMPLE REPORT LAYOUT** (Must be attached)**:**

SELECT TYPE OF MEDIA AND FORMAT FOR REPORT:

5. **MEDIA**
   - ☐ E-mail
   - ☐ Paper Report
   - ☐ CD-ROM

   Format
   - ☐ MS EXCEL (.xls)
   - ☐ ASCII (.txt)

6. **Return Request by: (Please check one)**
   - ☐ **E-mail**
   - ☐ **Fax**
   - ☐ **Pick Up**
   - ☐ **Mail**

Submission of this form serves as confirmation that the request conforms to the confidentiality provisions of Office of Health Care Access regulations.

Requestor Information:

_____
Name

_____
Company

_____
Street Address

_____
Town, State and Zip Code

_____
Telephone **and** Fax Number

_____
Email Address

Your bill for this service is:

Files on CD @ $5.00 per file	$
Paper Copies @ $.25/page	$
Programming and formatting fee @ $7.58/quarter hour	$
Postage & Shipping Charges (if applicable)	$
Total Amount Due	**$**

Payment: PLEASE MAKE CHECKS PAYABLE TO "TREASURER, STATE OF CONNECTICUT" AND REMIT TO THE OFFICE OF HEALTH CARE ACCESS. 410 CAPITOL AVENUE, MS#13HCA, P.O.BOX 340308, HARTFORD, CT 06134 AS SOON AS POSSIBLE. **PLEASE BE SURE TO INCLUDE ONE COPY OF THIS BILL WITH YOUR PAYMENT.**

Revised, December, 2004